3.3.6.1 Health Records Organization and Maintenance

(a) Policy

All California Department of Corrections and Rehabilitation (CDCR) dental personnel shall use the Electronic Dental Record System (EDRS) to document all dental treatment rendered to CDCR patients, including medications utilized during dental treatment.

(b) Purpose

To establish procedures for the correct documentation in the EDRS of dental services rendered to patients and to provide guidelines for the development, utilization and management of health records.

(c) Procedure

(1) General Health Record Organization and Maintenance

(A) A health record shall be maintained for each patient consistent with applicable laws and in accordance with Division of Health Care Services (DHCS) Medical Services Standards.

(B) CDCR dental personnel shall abide by EDRS Workflows and Job Aids as well as Electronic Health Record System (EHRS) Workflows in the utilization and management of patient health records. Only approved CDCR and CDC forms or forms generated by an outside dental/medical consultant, (e.g., Oral Surgeon), are to be included in the health record, (see Appendix 1 at the end).

(C) When the EDRS or EHRS are not available, dental staff shall implement downtime procedures. When this occurs, all paper forms shall be filled out completely including, but not limited to, the patient demographic information block located in the lower portion of some CDCR forms or at the top of other CDCR forms. This information must be completed if any entry is made on any part of the form.

(D) The health record shall contain the following:

1. Identification data.
2. Problem List (including allergies, special needs, chronic illness clinics, permanent medical passes, non-English speaking status, etc.).
3. Receiving, screening and health assessment records.
4. Prescribed medication and therapeutic orders.
5. Reports of laboratory, radiographic and diagnostic studies.
6. Clinic notes.
7. Special needs treatment plans, if any.
8. Immunization records.
9. All findings, diagnoses, treatment and dispositions.
10. Informed consent, treatment refusal and release of information forms.
11. All consultant's reports and procedural results.
12. Discharge summaries of inpatient admissions and hospitalizations.
13. Place, date and time of each health care encounter.
14. Signature, either electronic or handwritten, and title of each documenter.

(E) All verbal or telephone orders shall be signed or electronically authorized via Computerized Provider Order Entry as outlined in the Health Care Department Operations Manual, (HCDOM), Section 3.3.5.10(c)(1)(A) and (B).

(F) All dental encounters and services rendered, either direct hands-on care or indirect care, (e.g., radiological interpretations, written responses to CDCR 7362s, specialty clinics, on call contacts, consultations, or discharge summaries from inpatient admissions), must be documented in the health record at the time treatment is provided or when observations are made by the appropriate health care provider.

1. Prior to seating a patient in the dental operatory, dental staff shall confirm each patient's identity by verifying the individual's first and last name, date of birth, and CDCR number. The patient identification process shall be documented in a clinical note in the EDRS, in accordance with EDRS Workflow 1-2 and associated Back Office Job Aid.
2. Prior to performing any invasive, irreversible procedure, at least two dental clinical staff (Dentist, Dental Assistant, Dental Hygienist, Oral Surgeon) shall carry out a Time Out Protocol to confirm correct patient, correct procedure and correct site. The Time Out Protocol process shall be documented in a clinical note in the EDRS, in accordance with EDRS Workflow 1-2 and associated Back Office Job Aid.

3. EDRS clinical notes shall be signed no later than close of business the day treatment is provided or observations are made.

(G) Changes or error corrections to an existing clinical note in the EDRS shall be made by generating an addendum to the original document. For paper documents, the complete obliteration of any entry and use of correction fluid is prohibited. Changes or error corrections shall be made by drawing a single line through the information being changed or corrected. The individual making such changes shall initial, date and note the reason for the changes.

(H) All dental health care providers shall utilize the Subjective, Objective, Assessment, Plan, Education format in documenting patient care. Entries made in a patient's dental health record as the result of a visit for the evaluation or treatment of a specific or routine complaint must include, but are not limited to, the following:

1. Subjective – Patient's chief complaint or purpose of visit.
2. Objective – Objective findings.
3. Assessment – Diagnosis or clinical impression.
4. Plan – Proposed treatment plan.
5. Education – Patient education.

(I) Only approved CDCR forms are authorized for inclusion in the health record. The practice of using unapproved forms or making modifications to approved forms is not authorized for permanent inclusion in the health record. To avoid misinterpretations, only the approved list of symbols and abbreviations contained in the California Correctional Health Care Services Approved Abbreviations (MCV) shall be utilized. This does not pertain to the filing of appropriate clinical information.

(J) Health Information Management (HIM) shall ensure that a random sampling of health care forms and documents scanned into the EDRS Document Center are reviewed as part of the quality assurance process. In the event a health record is incomplete due to the death, resignation, termination, or incapacitation of the attending clinician, it shall be given to the unit health supervisor, or if they are the person who is no longer available, then the Chief Executive Officer or designee, or Supervising Dentist (SD) or designee at the local institution shall determine if some other provider on staff can complete the record.

(2) Dental Health Record Organization and Maintenance

(A) The following documents are authorized for scanning into the EDRS Document Center:

1. CDCR 237-F, Dental Pain Profile.
2. CDCR 239, Prosthetic Prescription.
3. CDCR 7225-D, Dental Refusal of Examination and/or Treatment.
4. CDCR 7342, Informed Consent to Surgical, Special Diagnostic, or Therapeutic Procedures.
5. CDCR 7362, Health Care Services Request Form.
6. CDCR 7423, Notification of Reception Center Dental Screening.
7. Dental Consent Forms
   a. CDCR 7422, Informed Consent for Silver Diamine Fluoride Treatment.
   b. CDCR 7424, Informed Consent for Root Canal Treatment.
   c. CDCR 7425, Informed Consent for Extraction(s).
   d. CDCR 7426, Informed Consent for Periodontal Treatment.
   e. CDCR 7428, Full and Partial Denture Agreement.
   f. CDCR 7429, Informed Consent for Dental Treatment.
8. CDCR 7441, Patient Acknowledgement of Receipt of Dental Materials Fact Sheet.
9. PIA – CCW – 006, PIA Prosthetic Prescription.

(B) When documentation is completed, the treating dentist or designee shall ensure all CDCR Dental forms listed in Section (c)(2)(A) are forwarded to the Office Technician (OT), or designated dental staff, for scanning into the EDRS Document Center. After scanning has been completed, the OT, or designated dental staff, shall forward the originals to HIM in accordance with EDRS Workflow 3.10-1.

(C) Proper and consistent documentation must be maintained to ensure compliance with applicable state and federal laws and regulations and DHCS, health record policy.

(D) Only approved methods as described in the EDRS Workflows and Job Aids shall be used for charting diseases, abnormalities, missing teeth, existing restorations and treatment completed while incarcerated.

(E) Health History Information

1. At the time of each initial or periodic comprehensive dental examination and prior to providing any dental treatment, a dentist shall review the patient's health history information in the EHRS and interview the patient using a standardized series of questions to validate the information.
2. Health history information shall be reviewed by each provider prior to providing dental treatment including prescribing medication. Documentation of a health history review shall be made in a clinical note in the EDRS, in accordance with EDRS Workflow 1-2 and associated Back Office Job Aid.
3. If in the professional opinion of the treating dentist there is a clinically significant discrepancy between the health history information the patient provides and the health history information in the EHRS, the treating dentist may place an order in the EHRS for a 'Consult to Primary Care Provider' to obtain clarification. This action shall be documented in a clinical note in the EDRS, in accordance with EDRS Workflow 1-2 and associated Back Office Job Aid.

(F) Treatment Plan

Treatment identified by a dentist shall be entered in the EDRS odontogram, in accordance with EDRS Workflow 1-3 and associated Back Office Job Aid.

(G) Authenticating Entries

1. Dentists are authorized to authenticate any entry in the dental health record and are *required* to authenticate direct patient care entries, patient refusals of treatment, and rescheduling or cancellation of any encounter.
2. Registered Dental Hygienists (RDH) are permitted to authenticate all entries authorized to a dental assistant and are authorized and required to authenticate entries pertaining to any RDH duty allowed and specified within the Business and Professions Code Sections 1907 to 1913.
3. (Registered) Dental Assistants (DA) are authorized and required to authenticate entries pertaining to: the provision of preventive procedures, screening (subjective and objective findings) of patients, receiving and disposition of CDCR 7362 requests and other non-direct patient care entries.
4. Office Assistants or OTs are authorized to transcribe on the dental forms those entries not requiring clinical judgment as determined to be appropriate by the SD. They may sign the transcribed entry, but the appropriate dental personnel (dentist, RDH, [registered] DA) must authenticate the entry. Examples of such transcription include, but are not limited to, the following:
   a. Entries pertaining to the receipt of a CDCR 7362 request.
   b. Patient "no show" or "failed" appointments.
   c. Issuance of toothbrush, flossers, etc.

(H) Clinical Notes

1. A narrative description of all dental services and any information determined to be appropriate by dental staff shall be documented in a clinical note in the EDRS, in accordance with EDRS Workflow 1-2 and associated Back Office Job Aid. Examples of supplemental information include, but are not limited to:
   a. Lab reports.
   b. Recommendations.
   c. Probable prognosis in doubtful or complicated cases.
   d. Failure to keep an appointment.
   e. Failure to follow health care provider's instructions.
   f. Refusal of recommended treatment.
   g. Placement on lay-in status.
   h. Appointments cancelled.
   i. Treatment rendered.
   j. Amount and type of anesthetic utilized.
   k. Medication prescribed.
2. Dental staff shall review the EDRS Signature Manager to identify unsigned clinical notes, in accordance with EDRS Workflow 4-3 and associated Back Office as well as Front Office Job Aids.
3. In the event an unsigned clinical note cannot be signed by the treating provider due to the death, resignation, termination, incapacitation, or unavailability of the individual, the SD or dentist designee shall be authorized to sign the clinical note for administrative purposes. The SD or dentist designee shall indicate

on the clinical note the reason they are signing on behalf of the treating provider prior to signing the document.

Revision History
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Appendix 1

Approved CDCR Dental and Medical Forms:

CDC 128-C, (MCV) Medical/Psychiatric/Dental. This chrono report shall be used for any pertinent notation that the attending practitioner requests be placed in the patient's EHRS or Central File. It is also used to record dental holds, a patient's refusal of treatment or refusal to appear for a priority appointment, as well as a patient's possession of a dental prosthetic appliance.

CDCR 237-A, (MCV) Reception Center Dental Screening. When downtime procedures have been implemented, this form shall be completed by the dentist as part of the initial dental screening of incoming patients at the RC.

CDCR 237-B, (MCV) Dental Examination and Treatment Plan. When downtime procedures have been implemented, dental staff shall use this form when completing a comprehensive dental examination.

CDCR 237-B-1, (MCV) Supplemental Dental Examination and Treatment Plan. When downtime procedures have been implemented, this form is used to note changes and additions to the dental treatment plan.

CDCR 237-C, (MCV) Dental Progress Notes. When downtime procedures have been implemented, this form shall be used to document clinical notes pertaining to dental treatments and visits.

CDCR 237-C-1, (MCV) Supplemental Dental Progress Notes. When downtime procedures have been implemented, this form provides additional space to document dental clinical notes.

CDCR 237-E, (MCV) Plaque Index (PI) Scoring Record. This form shall be used to record the patient's PI score.

CDCR 237-F, (MCV) Dental Pain Profile. This form is utilized by healthcare personnel to evaluate the level of pain associated with a patient's dental symptoms or for a stated dental emergency.

CDCR 239, (MCV) Prosthetic Prescription. This form must accompany each dental laboratory case sent to a California Department of Corrections and Rehabilitation (CDCR) dental laboratory during shipping and processing. The form must be completed, name stamped or name printed, and signed by the attending dentist, and must describe the prosthetic work to be performed by the dental laboratory.

CDC 7221, (MCV) Physician's Orders. When downtime procedures have been implemented, this form is used to document verbal or written orders issued by licensed health care staff in the course of providing treatment to a patient. It is also utilized when requesting consultations or making referrals between medical and dental staff at an institution.

CDCR 7225-D, (MCV) Dental Refusal of Examination and/or Treatment. This form shall be completed when a patient refuses to submit to a dental examination and/or dental treatment.

CDC 7243, (MCV) Health Care Services Physician's Request for Services. This form shall be used when requesting specialty consults or treatment by outside health care providers.

CDC 7252, (MCV) Request for Authorization of Temporary Removal for Medical Treatment. This form is completed by a Registered Nurse (RN) when it becomes necessary to transfer a patient to an outside facility for health care services.

CDCR 7257, (MCV) Medical/Dental Lay-in Order. When downtime procedures have been implemented, this form shall be completed by a dentist to document that a patient is being placed on a medical/dental lay-in. Use of this form is not necessary when the dentist elects to generate a CDC 128-C, (MCV) Medical/Psychiatric/Dental chrono for the lay-in.

CDCR 7277, (MCV) Initial Health Screening (All Institutions). When downtime procedures have been implemented, this form shall be completed at Receiving and Release (R&R) by health care staff for all newly arriving patients, including new commitments and parole violators.

CDCR 7277-A, (MCV) Initial Health Screening (Supplemental) – Female Inmates. When downtime procedures have been implemented, this form shall be completed at R&R by health care staff for each newly arriving female patient, including new commitments and parole violators.

CDC 7293, (MCV) Conditions of Admission/Placement. This form shall be signed by each patient admitted to an inpatient setting, or placed in an outpatient-housing unit.

CDC 7342, (MCV) Informed Consent to Surgical Special Diagnostic, or Therapeutic Procedures. This form shall be used by dentists as well as physicians.

CDCR 7362, (MCV) Health Care Services Request Form. This form shall be used by patients to request a dental appointment.

CDCR 7385, (MCV) Authorization for Release of Health Care Record. This form shall be used by all patients requesting authorization for release of information from their health record, or from a previous health care provider.

CDCR 7422, (MCV) Informed Consent for Silver Diamine Fluoride (SDF) Treatment. This form is to advise patients of the risks, benefits, or complications of SDF treatment and must be signed by the patient and the treating dentist prior to beginning SDF treatment. (Reference the HCDOM, Section 3.3.6.2(c)(2) for validity and duration of consent).

CDCR 7423, (MCV) Notification of Reception Center Dental Screening. This form shall be completed by all RC patients diagnosed during the RC dental screening as having DPC 2, 3, or 5 dental needs to inform them that they could benefit from dental care.

CDCR 7424, (MCV) Informed Consent for Root Canal Treatment. This form is to advise patients of the risks, benefits, or complications of root canal treatment and must be signed by the patient and the treating dentist prior to beginning the root canal. (Reference the Health Care Department Operations Manual (HCDOM), Section 3.3.6.2(c)(2) for validity and duration of consent).

CDCR 7425, (MCV) Informed Consent for Extraction(s). This form is to advise patients of the risks, benefits, or complications of extractions and must be signed by the patient and the treating dentist prior to beginning the extraction. (Reference the HCDOM, Section 3.3.6.2(c)(2) for validity and duration of consent).

CDCR 7426, (MCV) Informed Consent for Periodontal Treatment. This form is to advise patients of the risks, benefits, or complications of periodontal treatment and must be signed by the patient and the treating dentist prior to beginning the periodontal treatment. (Reference the HCDOM, Section 3.3.6.2(c)(2) for validity and duration of consent).

CDCR 7428, (MCV) Full and Partial Denture Agreement. This form is to advise patients of their eligibility, and to outline the requirements for having full or partial dentures made. The form must be completed and signed by the patient and the treating dentist prior to taking impressions for full or partial dentures. (Reference the HCDOM, Section 3.3.6.2(c)(2) for validity and duration of consent).

CDCR 7429, (MCV) Informed Consent for Dental Treatment. This general consent form is used to advise patients of the risks, benefits, or complications of dental treatment and must be signed by the patient and a dentist prior to beginning dental treatment. (Reference the HCDOM, Section 3.3.6.2(c)(2) for validity and duration of consent).

CDCR 7431, (MCV) Periodontal Chart. When downtime procedures have been implemented, this form shall be completed as part of a comprehensive periodontal examination.

CDCR 7441, (MCV) Patient Acknowledgement of Receipt of Dental Materials Fact Sheet (DMFS). This form shall be signed by each patient upon receipt of the DMFS.

CDCR 7443, (MCV) Dental Health History Record – English. When downtime procedures have been implemented, this form shall be completed when treatment is rendered and shall list any past or present illnesses, medications currently being taken, or allergies to medications, etc.

CDCR 7444, (MCV) Dental Health History Record – Spanish. When downtime procedures have been implemented, this form shall be completed by Spanish speaking patients when treatment is rendered and shall list any past or present illnesses, medications currently being taken, or allergies to medications, etc.

PIA – CCW – 006 (MCV) Prosthetic Prescription. This form must accompany each dental laboratory case sent to the PIA Dental Laboratory during shipping and processing. The form must be completed, name stamped or name printed, and signed by the attending dentist, and must describe the prosthetic work to be performed by the dental laboratory.